

**County/Direct Provider User Cancellation**

ADP 100131(New 08/02)

**For Canceling User Access to Confidential ADP Drug Medi-Cal Information****County/Direct Provider/Vendor:** \_\_\_\_\_ (County/Direct Provider /Vendor Name and Number)

To ensure the confidentiality of county/direct provider Drug Medi-Cal data, the Department of Alcohol and Drug Programs (ADP) requests the County ADP Administrator, Direct Provider/Vendor Executive Officer to notify ADP when previously-approved users should no longer be allowed access to confidential patient data in the systems listed below. Please provide this information below and fax this form to (916) 323-0653. If you have questions about this form, please call (916) 323-2043.

**User No Longer Authorized Access as of \_\_\_\_\_ (Date)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Username: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

**User No Longer Authorized Access as of \_\_\_\_\_ (Date)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Username: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

**User No Longer Authorized Access as of \_\_\_\_\_ (Date)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Username: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

**ADP Administrator/Executive Officer Certification:**

As ADP Administrator/Executive Officer for \_\_\_\_\_ County/Direct Provider/Vendor, I request that the above individuals no longer have access to specific confidential Drug Medi-Cal patient data.

\_\_\_\_\_  
County ADP Administrator/Direct Provider Executive Officer (signed and printed)\_\_\_\_\_  
Date